PREVENTIVE LAW: THE CALIFORNIA REHABILITATION CENTER

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INTRODUCTION

California in 1961 launched a major program to provide for the control and treatment of narcotic addicts. The program anticipated by less than one year a United States Supreme Court decision[1] declaring unconstitutional a California statute making it a criminal offense to be addicted to the use of narcotics.

The program provides for two phases of treatment, one as an "inpatient" undergoing therapy at the California Rehabilitation Center (CRC) and one as an "outpatient" readjusting to living in the community under careful supervision.

Although the initiating of commitment proceedings in some cases may be the result of apprehension of the narcotic addict on a criminal charge, commitment itself is by a civil procedure in the superior court. This procedure is patterned after commitment proceedings for the mentally ill, and many of the same statutes apply to both types of commitments.

The constitutionality of the narcotic addict rehabilitation program already has been tested in the California courts.[2] Although the court found the program constitutional, it criticized the "indicia of criminality" contained in the original legislation. Based upon that decision the legislation was amended to set forth a detailed statement of legislative intent and to remove various terms and phrases normally associated with punitive statutes.

This article will generally review the authorizing legislation and commitment procedure without a detailed analysis.[3] The inpatient and outpatient treatment will be discussed and the attitude of the patients will be illustrated by an interview with a patient at CRC. Although it is still too early to see any significant impact on the narcotics problem, early results will be reviewed and projections made as to future developments.

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1 Robinson v. California, 370 U.S. 660 (1962).

2 *Ex parte* De La O, 59 Cal. 2d 128, 378 P.2d 793, 28 Cal. Rptr. 489, *cert. denied*, 374 U.S. 856 (1963).

3 For a thorough discussion of this legislation in its present form see Note, *California Narcotic Rehabilitation: De Facto Prison for Addicts?* 1 SAN DIEGO L. REV. 58 (1964).

A. General Background

Typically, narcotic addicts have become delinquently oriented and have long histories of antisocial behavior. Usually they are not only addicts, but in most cases have stolen, burglarized, robbed, forged, peddled narcotics or committed other offenses. Some have been hostile even to the point of belligerence. Some would try every means of escape possible if confined, and many will go to great lengths to get narcotics during a confinement period. They not only present treatment problems, but also are serious management problems. A treatment facility, therefore, must be equipped and staffed to keep narcotic addicts in and narcotics out. Any outpatient program requires a statewide network of agents to supervise, guide and assist the outpatient and, through this supervision, guidance and assistance, to protect the public by reducing returns to use of narcotics and returns to crime to support narcotic habits.

Experience in a special research program, the Narcotic Treatment Control Project (NTCP), which California initiated in 1959, provided the basis for the rehabilitation program. The NTCP was initiated to develop better methods of control and treatment of narcotic users paroled after serving prison terms for criminal offenses. This California research project, which is still under way among felon parolees, concentrated on small caseload supervision, anti-narcotic testing to determine return to drug use, and short-term reconfinement with treatment for parolees who have returned to drug use. The use of group counseling in the Center, the community anti-narcotic testing of the outpatient, and a short-term retreatment plan for outpatients found to have returned to drug use, are concepts derived from the NTCP.

Unfortunately, there is no panacea for heroin addiction. Experience in the continuing NTCP research program indicates, however, that intensified supervision in the community is beneficial; and it is even more successful when it follows intensive institutional treatment.

Drafting of the 1961 legislation leading to establishment of the CRC program involved recommendations by the Governor, the Attorney General, the Governor's Special Study Commission on Narcotics, the Department of Mental Hygiene, law enforcement agencies, the judiciary, and the Department of Corrections. The legislation, as finally enacted, provided:

(1) A program of civil commitment for treatment for volunteers who believe themselves addicted or about to become addicted, for non-volunteers identified as narcotic addicts or in

imminent danger of addiction, and for persons convicted of misdemeanors and certain felonies whose basic problem appeared to be narcotic addiction or excessive use of narcotics.

(2) A compulsory period of legal control (institutional and outpatient) for therapeutic reasons.

B. COMMITMENT PROCEDURE

The civil proceedings under which the addict may be committed are initiated in one of four ways:

(1) A person believing himself addicted, or about to become addicted, may report his belief to the district attorney. The district attorney may then petition the superior court for consideration of the addict's commitment.

(2) Any other responsible person who believes that a person is addicted, or in imminent danger of becoming addicted, may report him to the district attorney; and once again, the district attorney may petition the superior court for consideration of commitment.

(3) Any person convicted of any crime in a municipal or justice court, if the judge believes he is an addict, or is in imminent danger of becoming addicted, may be sent to the superior court to determine that issue.

(4) With some exceptions, any person convicted of a crime in superior court, if the judge believes he is an addict or in imminent danger of becoming addicted, may also be examined to determine whether he is addicted or in imminent danger of addiction.

In the latter two cases where there have been criminal convictions, the judges may adjourn proceedings and suspend sentencing pending a determination as to whether the addict should be committed to CRC, and if committed, completion of the CRC program, as both an inpatient and an outpatient.

The commitment proceedings are essentially those employed for the commitment of the mentally ill. They insure that the constitutional rights of the person whose commitment is sought are protected. They provide, for example, that the patient be taken before a judge and informed of his rights, that he be examined by qualified medical examiners, that he be given ample opportunity to produce witnesses in his behalf, that he be personally present in open court and that he have court appointed counsel if he is unable to employ his own. If the judge acts to commit the person to the California

Rehabilitation Center, the person so committed may demand a jury or court trial on the issue of his addiction.

Once the person is committed, he is committed for a definite period even though he may have volunteered himself for treatment. The law now provides for a 2½ year commitment for volunteers and a 7 year commitment for others. A minimum of six months must be spent as an inpatient in either case. The addict may then be placed in an outpatient status by the Narcotic Addict Evaluation Authority. If one whose commitment was initiated by a conviction abstains from the use of narcotics for three consecutive years, he may be discharged from his commitment, and the criminal charges against him may be dropped. The law, recognizing the reality of potential relapse, also provides for a return to inpatient status upon detection of narcotic use or for other pertinent reasons. Commitment periods of non-volunteers may be extended up to a maximum of ten years. There is also provision made for persons ineligible for discharge at the expiration of their commitment. They must be returned to court for imposition of the original sentence, if their commitment was initiated due to a conviction, or perhaps for recommitment to the CRC program regardless of the circumstances initiating the original commitment.

C. Institutional Treatment

When the addict is committed to the Rehabilitation Center, he is immediately assigned to a group of 60 residents with whom he will remain until he is returned to the community. Women addicts are received in a separately fenced area in the Center. Programming for the women is identical, but it is separate from the men's programming.

The initial diagnosis is undertaken by psychologists and counselors who will continue to work with the residents. The new resident receives a great variety of tests including I.Q., educational achievement, vocational aptitude and personality tests. His social and criminal history is compiled. Not only is information secured directly from the resident but a field study also is undertaken. In this study local contacts are explored. Ex-employers, the police, former teachers, family members and others may be interviewed by CRC representatives to fill in the gaps and to confirm details of the resident's history. The counselling staff also makes a special effort to develop the narcotic history. From this array of information, staff members develop a recommended treatment program.

The emphasis within the institution is upon group or community living. The living units, composed of 60 men each, are the basic

treatment groups. Large group meetings are held daily, five days per week, and include all dormitory residents plus their staff. This is patterned after group therapy techniques developed by the U. S. Navy and by mental hospitals.

These large groups begin by discussing the problems of everyday living in an institution. For example, they talk about their problems with each other, with their work assignments and with staff members, such things as pilfering and informing and other conditions which might exist in their living unit or in the institution as a whole. They expand from these topics to talk about the relationships they have with friends and family on the outside. They progress, or are led, into a discussion of all these problems in relation to themselves, the questions being how much they are causing their own problems and how much they are contributing to the problems of others.

Large group meetings are important. They serve as relief valves, giving the men a chance to express themselves on so-called grievances. They provide clues for the staff counselors. These clues later can be followed up in small groups or in individual counselling. They help the addict residents to understand each other and, in the give and take of the large group, the addicts very often see themselves in others, begin to analyze their own attitudes and generally come to grips with feelings about themselves.

The large group meetings are followed by staff meetings, in which the staff members evaluate what happened and what was said. They pinpoint the problems that were identified in the exchanges and plan methods of solution. In addition, they determine the areas in which they feel further discussion should be encouraged.

Two or three days each week, in addition to the large group meeting, the 60-man group is divided into four 15-man groups for an hour or more of intensive group work. In these small group sessions, the residents get closer to their basic problems, the immaturity, the emotional difficulties, the attitudes and the actions which may have led them to addiction and ultimately to the institution.

In these small group sessions, the addict residents become deeply involved. They describe their own problems; they critically analyze the comments of others; and they learn to perceive the phony explanation and to expose it. In their frank discussion they put individual problems on the line and discuss them in depth. Thereby, they develop the kind of insight that hopefully will lead them individually to more mature thinking and ultimately to more constructive living.

One of the hopeful signs in this program is the continuing of the discussion into the residents' free time. They frequently cluster in small groups to continue the discussions that arose in the formal group sessions.

Through training and experience, the CRC staff members have learned to develop the kind of constructive relationship with the residents that leads to considerable individual counselling as well.

The program, of course, is broader than group counselling and group therapy. It must be recognized that many of the addicts sent to CRC are untrained, have never been able to hold or in some cases even to secure adequate jobs in a community; most have not completed high school. Therefore, there is a full academic program through the elementary and high school level. Vocational courses, in which competence can be obtained in a relatively short time, are also included. The institution's maintenance and service programs have been designed for maximum in-service training. For example, the laundry and drycleaning equipment is similar to that in most modern plants of any size in California. Addict residents can learn such trades as upholstering, laundering, drycleaning, baking, general shop, building maintenance, landscape gardening, house painting, cooking and several others. Also, there is the required work on regular projects as they are needed throughout the institution. Recreational fields, handball courts and so on have been developed largely by the addicts themselves.

Music, art, crafts, public speaking and other forms of self-expression are encouraged in off-duty hours. The reason for this is that many of the residents have never learned how to make constructive use of leisure time. The fact is that some of them have engaged only in spectator sports, and few of them have been concerned about physical fitness. While there is a program of individual sports and recreation and individual hobbies, residents are encouraged also to take part in team sports in order that they may learn to cooperate, coordinate, work with and assist others. The effort is to lead them toward a well-rounded community life.

Because it is recognized that many narcotic addicts have family difficulty and face the possibility of family condemnation, family criticism and family suspicion when they return to the community, residents are encouraged to have their families visit with them and become involved in group counselling sessions with the staff. The hope here obviously is that the family with more understanding of the addict's problems will be able to work with him instead of

against him during the early period of his outpatient status. It is also hoped when the resident returns to the community, because of his new awareness of his family's problems in understanding and getting along with him, he will be able to fit in better as a family member.

This institutional treatment program is based on experience indicating that persons who become addicted to narcotics are generally socially inept, lacking in empathy, dependent, impulsive and selfish.

In addition to the help derived from the formal treatment program, many of the residents are able to derive personal assistance through the institution's religious program which has the full time services of a Catholic priest and a Protestant minister, and the part-time services of a Jewish rabbi.

D. Adjustment to Community Living

The institutional program is only the first phase of rehabilitation. The real test comes in the community and only in the community. It was in the community that the addict failed in the first place. It is in the community that he will fail again unless he has the kind of continuing supervision, counselling and advice that he needs. The outpatient program, therefore, is a vital part of the CRC plan.

The decision as to when a resident is ready for transfer to outpatient status lies with the Narcotic Addict Evaluation Authority. This three-man board meets at CRC regularly to review cases presented to it by the staff, and also to review annually those cases not specifically referred to it by the staff, to determine whether the resident is ready for outpatient status.

The present Narcotic Addict Evaluation Authority includes Dr. Victor H. Vogel, a former medical director of the Federal Narcotic Addict Hospital at Lexington, Kentucky, Mr. Martin Ortiz, a social worker active in the Los Angeles area, and a former Los Angeles Police Captain, Jack A. Donahoe.

The staff report presented to the Narcotic Addict Evaluation Authority covers in considerable depth the resident's home background, his participation in institutional programs, and his progress. Work supervisors, for example, provide reports. A man might be assigned to a laboring crew outside, to a landscaping crew, to a cleanup crew, or what have you. His work supervisor, in this case, would submit a report on his performance at least quarterly. Then, too, there are the school grades provided by instructors. Also included are analyses by the officers assigned to supervise and counsel the 60-man dormitory

groups. All staff personnel with whom the resident has regular or even intermittent contact are required to submit reports.

In preparing the reports for presentation to the Authority, the responsible counselor has to consider the man's total progress, not merely how he does in the treatment counselling group. A man who participates in discussions and communicates effectively may sound like a good prospect for outpatient status. However, how much does it really mean? How deep-seated is the change he appears to have made? How is this change reflected in his performance? In his dormitory in maintaining himself? In his conduct in school? On the job? In recreation? And in other programs? Has he had any disciplinary action? Does he adhere to institution regulations? These are questions which, of course, must be answered.

The resident does not apply for consideration by the Authority for release to outpatient status. The earliest he could legally be released would be after the completion of six months as a resident. The staff, therefore, no sooner than four and a half months after the man is received and no later than six months after arrival, reviews the case to consider possible referral for release.

If the counselor feels that referral is in order and the supervising counselor agrees, the case is then referred to the CRC Field Services Division. This Division investigates the environment and circumstances to which the man might be released to make certain that he will have a satisfactory outpatient program awaiting him.

That report, together with the counselor's evaluation report, is presented to the superintendent, who, acting for the Director of Corrections, reviews the case. If he feels that release is in order, he certifies the case as worthy of consideration for release and forwards it to the Narcotic Addict Evaluation Authority. The resident then appears before the Authority. If after the hearing it is so ordered, he is released to the community. While he may be released after six months, the average period of institutional treatment is approximately fourteen months.

CRC staff and the Narcotic Addict Evaluation Authority obviously do not expect completely successful rehabilitation in the initial outpatient period. Considering the depth of the patient's addiction problem and from the experience in programs that have preceded CRC, relapse, sometimes more than once or twice, certainly must be expected. It is important that outpatient agents be alert not only for return to use of narcotics or return to some form of crime, but also for early signs of delinquent behavior—heavy drinking; failure to

maintain adequate employment; continuous difficulty with family, neighbors, employers, or others; association with known addicts; or violations of other conditions of release. These danger signals must lead the agent to return the outpatient for further institutional treatment, with the consent of the Narcotic Addict Evaluation Authority.

This is somewhat similar, obviously, to the approach to the medically ill person, for example, the pneumonia case. When a man leaves a hospital after treatment for pneumonia, the doctor certainly remains alert during the convalescent period. If he sees a relapse coming, he gets his patient back to the hospital. This is the philosophy in the CRC outpatient program.

The outpatient agents are aided considerably, of course, by the anti-narcotic (Nalline) testing program which is combined with a urinalysis program in a system of regularly scheduled and surprise checks to discover whether the addict has returned to use of narcotics. The great majority of addicts are returned to the Center because of new narcotic use, or because of delinquent signs of a trend toward new narcotic use short of outright criminality.

Actually the outpatient agents begin working with the addict long before his release to the community, in fact shortly after his commitment. The case worker contributes an extensive review of the resident's home environment, family feelings, attitudes, work record, and prospects to the case history while the initial summary is being compiled. Often during this period the case worker makes his first contact with the resident who eventually may be in his outpatient caseload.

When the institution staff feels the resident is ready to leave, the case worker to whom he will be assigned contacts him. Together they work out release plans and begin to develop an effective working relationship.

These outpatient agents are specially trained to work with addicts and carry caseloads of thirty patients.

The first few months of the outpatient period are critical. Then the outpatient is hopefully trying to put to use what he has learned in the institution. Some men and women will need extra assistance during this period. This assistance may be provided by residence in a halfway house facility. At present, some addicts do go from the institution to halfway houses operated by volunteer agencies. However, because the Department of Corrections recognizes the value of the halfway house for many of its outpatients, it has secured from

the Legislature funds to develop two halfway houses specifically for patients from CRC. The initial two — one for men and one for women — are planned for Los Angeles County which is the source of the majority of commitments to the CRC program.

E. The Research Program

Although there has been a great deal of interest and concern shown in research on habit-forming drugs, still little is known about the addict himself. We are prepared to undertake research along these lines. At the California Rehabilitation Center we have the unique advantage of having a specific mandate of law to conduct research. The research program is under the direction of Edmund C. Gaulden, M.D., Chief of Research, who has a considerable background in medical research.

We see the need for well-structured research in the medical, physiological, psychiatric, psychological, and sociological aspects of narcotic addiction. Some of the questions we are prepared to ask ourselves are these:

1. Is there a specific physiological process which develops in narcotic addiction and is this process subject to control?
2. What is the nature of addiction, independent of the addicting agent?
3. Is there an addiction-prone personality and, if so, what are its dimensions?
4. What are the sociological factors in addiction; why do some social groups tend to have a higher addiction rate than others?
5. What is the relationship between narcotic addiction and various forms of social maladjustment generally described as criminal?
6. What happens as a result of our community group approach?

These and many other questions need answering before we can hope to "cure" narcotic addiction. An important part of our task at CRC is to start answering some of these questions and to exploit the interest of others in an attempt to answer them. Our research budget, as such, is not large, and we are going to have to rely on the interest of the major universities, the national institutes of health, and the large research foundations to undertake much of the needed research. Our grant applications are now being reviewed by the National Institute of Mental Health.

F. The Attitude of the Patient

How does the addict himself feel about the CRC program? Here are some answers given a visitor in a group counselling session:

QUESTION: "Do you think it would be possible in a dormitory like this to help your fellow man to correct his attitude? Do you think you are going to be able to change any of your attitudes?"

ADDICT: "Yes! I'll tell you why I think we can change attitudes—because, I think, so often people form attitudes to satisfy other people and not themselves. A man wants to look good in the eyes of his peers. He will do a lot of things to make himself look good to other people. When he finds out that this isn't what they really want, then maybe his attitude will change; then his behavior will change and he will find more satisfaction out of the changing of his behavior."

QUESTION: "You really think, then, that you can change your attitude?"

ADDICT: "I think so."

QUESTION: "Is there any one here who feels he is not being helped? I say this in all sincerity. If you feel you are being helped, I would like to know about it too."

ADDICT: "I think everybody here is being helped."

QUESTION: "Do you think the program should be continued?"

ADDICT: "I definitely do. If this program were in effect 15 years ago, perhaps I would have saved myself some time."

QUESTION: "You are being realistic now? You are not just doing your time here in order to get out and start again?"

ADDICT: "The more time we sacrifice in here, the more we are going to gain something.

"My brother is doing a lot of time in the federal penitentiary. He said, 'If they had a program like this back when I started, I probably wouldn't be in the situation that I'm in now.' He's doing thirty years in the penitentiary."

G. PROGESS SINCE THE INITIATION OF THE PROGRAM

Since the activation date, September 15, 1961, more than 3,900 commitments have been received in the Civil Addict Program. Presently, there are about 1600 men and 250 women in the Center. In addition, there are about 1,100 more addicts in the outpatient program. Of the approximately 1,850 persons in the Center, about 318 are returnees.

It is too early to make broad statements about the relative success of the CRC program. The probability is that the CRC program will

change with experience, and as new techniques are developed, the operation will be improved. The fact is, however, that early results are encouraging, this major effort to deal with large numbers of addicts is showing certain signs of success in terms of reduced addict crime and reduced relapse to drug use.

Of the initial 300 male addicts placed under outpatient supervision, after a year about 30 per cent had not returned to drugs or encountered other difficulty. These men were still in the community in an uninterrupted outpatient status. Of all those transferred to outpatient status since the center's opening, three per cent have been returned because of felony convictions, and four per cent because of misdemeanor convictions. Other returns were largely for relapse to drug use or borderline breakdown in behavior.

To put these figures in perspective it should be noted that a recent research project at the Federal Narcotic Addict Treatment Center at Lexington, Kentucky, indicated that of about 500 persons released from the institution only nine per cent went through the first six months without a return to narcotic use, entering a hospital or going to jail.

CONCLUSION

Rehabilitating and controlling narcotic addicts is possible and a reasonably good job is being done in California with this phase of the problem. The elements of control and treatment being performed by the California Department of Corrections and the California Rehabilitation Center and its legal basis have been described.

The Department of Corrections, in the regular facilities of the Department and in the California Rehabilitation Center, has thousands of narcotic addicts under its care. They must be handled now in the "best way possible" within the limitations of budget, physical facilities and staff skills. Addicts who end up in prison and/or in the Center have embraced a way of life which is foreign to most Americans. In some cases, they are escaping a situation they can no longer accept; in others, they are seeking acceptance and companionship in the only place and circumstances in which it seems available. Imprisoned addicts are generally looked down upon in the prison community. If allowed to assemble without proper leadership, addicts tend to discuss in great detail and relive their narcotics experiences. The "best way possible" to work with the addict in a controlled situation is first to insure a drug-free environment and secondly, to provide some structured experiences that utilize and capitalize upon his interest as soon as it becomes evident so that he begins to find a new and hopeful direction in life.

Somewhere in the process of rehabilitation, the addict must come to an honest encounter with himself. He must find the desire and effort to hold a job. He must discover some concern and feelings for others and the many other characteristics which develop self-respect and make life worth living.

In effect then, the California program is specifically designed to:

1. Get addicts off the streets. Reduce their chances of contaminating other men and women with the same infection. Dry up the market for heroin peddlers. Protect society from addict crimes.
2. Provide logical treatment for addicts.
3. Control and assist the outpatient as he readjusts to life in the community through intensive supervision, testing for drug use, and counselling.
4. Return them to the Center for additional treatment if they cannot make the adjustment to living in the community.